



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

ALLIED MEDICAL CENTERS  
PO BOX 24809  
HOUSTON TEXAS 77029

DWC Claim #:  
Injured Employee:  
Date of Injury:  
Employer Name:  
Insurance Carrier #:

#### **Respondent Name**

HARRIS COUNTY

#### **Carrier's Austin Representative Box**

Box Number 21

#### **MFDR Tracking Number**

M4-12-0300-01

#### **MFDR Date Received**

September 26, 2011

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "According to the AMA/CPT manual, the code 99214 is described as follows: Office or other outpatient visit for the evaluation & management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision, making of moderate complexity. Physicians typically spend 25 minutes face to face with the patient and/or family. Our doctors usually spend 25-30 minutes conducting a re-evaluation of established patients. As noted in the typed subsequent report that was submitted with the HCFA billing, you can clearly note that a comprehensive history is documented under Present Medical Condition on our follow-up exam form. A comprehensive examination including neuro & ortho exams were also performed and documented in the exam form. Decision making of moderate complexity was also met and documented in the treatment plan. Plan is noted in the report as well as discussing current medication and referral recommendations."

**Amount in Dispute:** \$171.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The medical records submitted to the claims department do not support the above requirements. Specifically, there was no documented detailed history, the exam portion consists of the weight, blood pressure readings, pulse and written statement under 'Neurological' stating 'no change', there is no written evidence of medical decision making of moderate complexity and the start and end time of the exam is not documented. Regarding code 99080-73, part II (b) is not complete. There is no specific information that provides through what date the restrictions are to last. The bill for the date of service at issue was denied because the provided documentation did not support either procedure code that was billed."

**Response Submitted by:** Thornton, Biechlin, Segrato, Reynolds & Guerra, L.C.

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 8, 2011	99214 and 99080	\$171.00	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

## **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §129.5 sets out the Work Status Report guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

### **Explanation of benefits**

- 150 – Payer deems the information submitted does not support this level of service.
- 193C – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. \*Documentation does not justify the level of service billed.\*
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 16H – Claim/service lacks information which is needed for adjudication. \*DWC form -73 was not properly completed per Rule 129.5 or was submitted in excess of the filing requirements.\*

## **Issues**

1. Did the requestor submit documentation to support the billing of CPT code 99080-73?
2. Did the requestor submit documentation to support the level of service billed?
3. Is the requestor entitled to reimbursement?

## **Findings**

1. Per 28 Texas Administrative Code §129.5 (i) Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be \$15. A doctor shall not bill in excess of \$15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section."
  - Review of completed DWC Form-73 does not meet the minimum documentation requirements for completing the form. As a result, reimbursement cannot be recommended.
2. The respondent denied reimbursement for CPT code 99214 based upon EOB denial code: "150 – Payer deems the information submitted does not support this level of service and 193C – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. \*Documentation does not justify the level of service billed.\*"
  - CPT code 99214 is defined as "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
3. Per 28 Texas Administrative Code §134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."
  - Review of the office visit note dated July 8, 2011 does document the minimum requirements for billing the office visit coded 99214. As a result, the requestor is not entitled to reimbursement for CPT code 99214.

## **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### Authorized Signature

_____	_____	July 26, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**